Title: "Role of Medical Records in the Revenue Cycle"

Session: 15 Mar 11 – 1630-1720

- ❑ Overview of the revenue cycle
- ❑ Define key roles, components and performance measures of the revenue cycle
- ❑ Provide an understanding of the Medical Records role in the revenue cycle management
- ❑ Explain key functions within Medical Records that impact the reimbursement process
- ❑ Identify opportunities for performance improvement
- ❑ Explain the connection between Medical Records and Denial Management/Revenue Cycle Team
- ❑ Discuss best practices for revenue cycle management
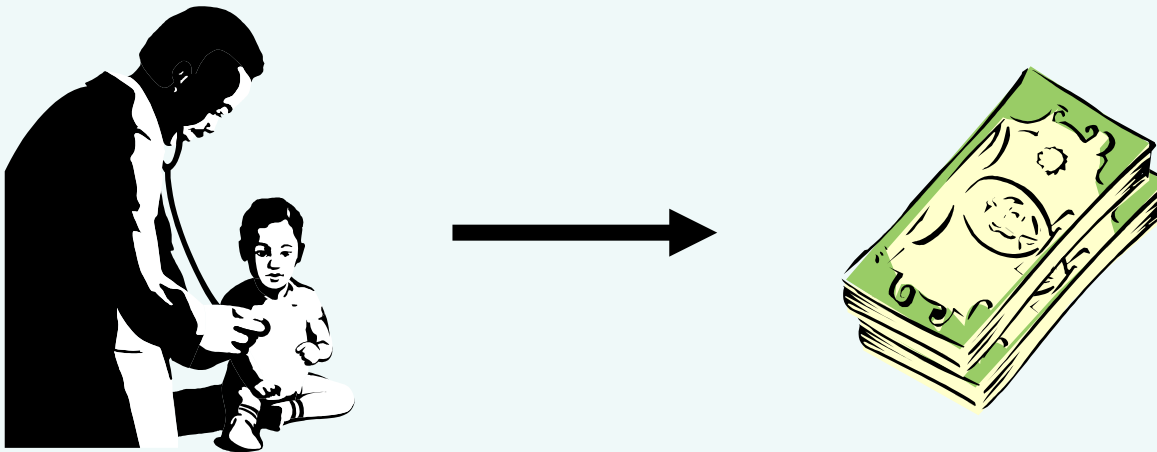
Definitions:

- **Revenue**
- Sum earned measured in dollars
  - What MTF earns
- **Accounts Receivable**
  - Accounts that have been billed but have not been paid
- **A/R Days**
  - Days of revenue in coding
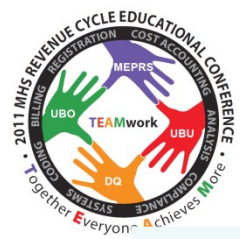   - Days are counted from date of discharge

Definitions

- **Discharged, not final billed (DFNB)**
  - Patients are discharged but bill is not sent out yet
  - Also known as "Unbilled Report"
- **Charges**
  - Description of services and price
- **Bill Hold Days**
  - "waiting period" that allows for the posting of charges, make corrections, or apply any additional diagnosis or procedure coding

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❑ What is the Revenue Cycle?

➢ All administrative and clinical functions that contribute to the capture, management and collection of patient service revenue (*HFMA)
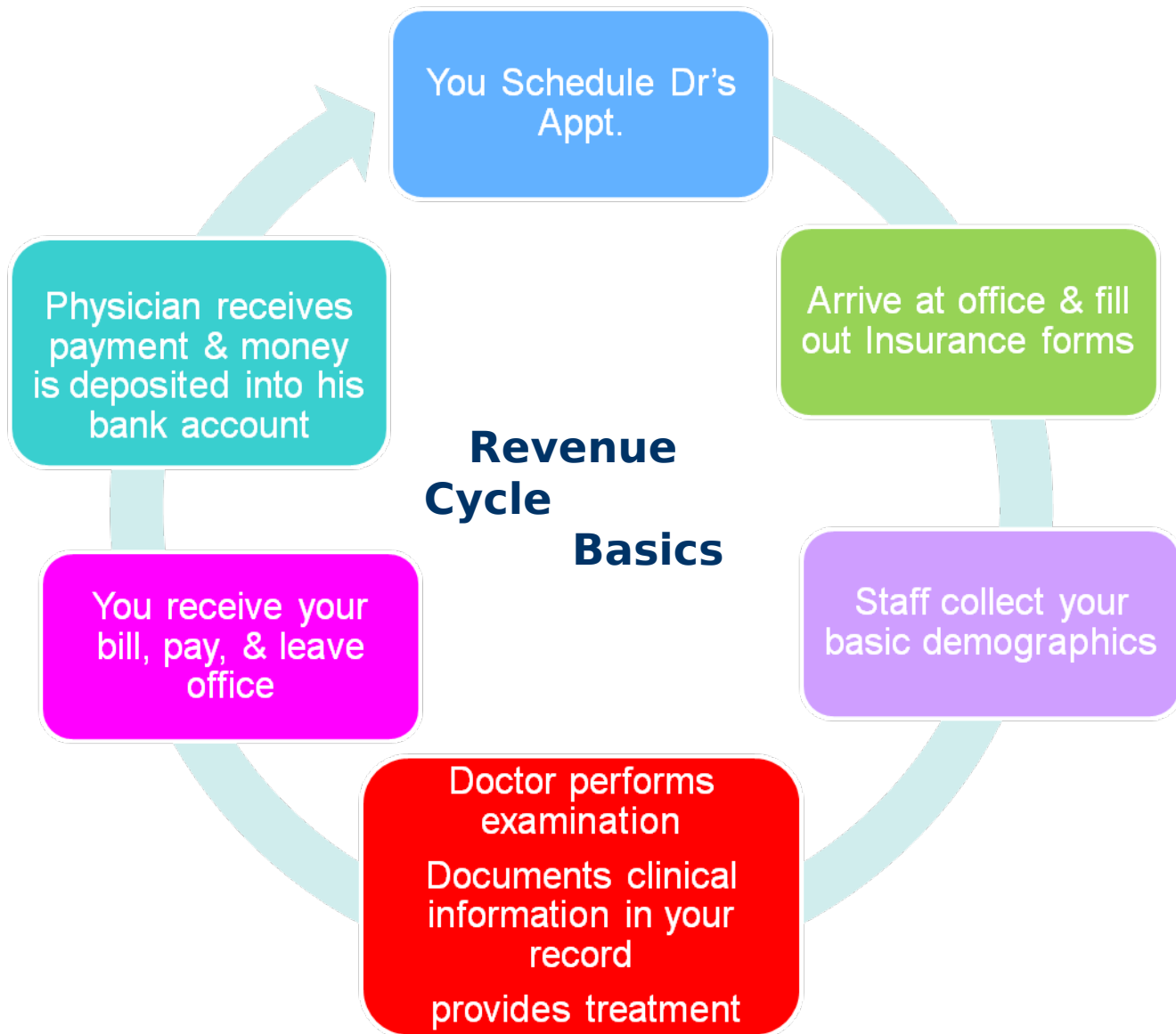
- ❑ Hospitals operate as a business
- ❑ Facilities/Providers need to ensure payment is received for services rendered
- ❑ Money collected is returned to MTF
  - ❑ Used for purchasing needed equipment, supplies and services
  - ❑ Payroll
- ❑ Need processes in place to collect reimbursement
  - ❑ Front-end processes
  - ❑ Back-end processes

Revenue Cycle Basics

- You Schedule Dr's Appt.
- Arrive at office & fill out Insurance forms
- Staff collect your basic demographics
- Doctor performs examination / Documents clinical information in your record / provides treatment
- You receive your bill, pay, & leave office
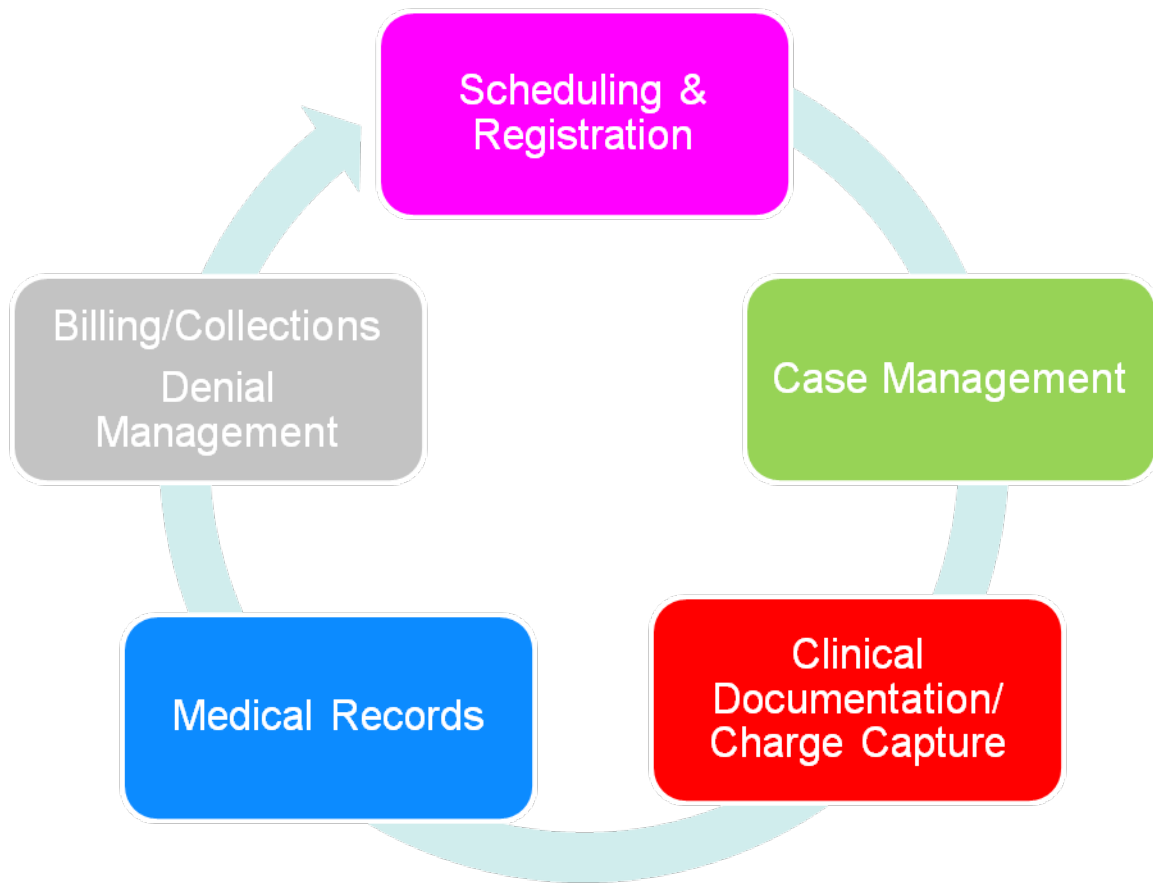- Physician receives payment & money is deposited into his bank account

- Patient Administration/Admitting

- Clinical Services (Charge Capture)

- Case Management

- Medical Records

- Billing/UBO

- Administration

- Finance
- IT

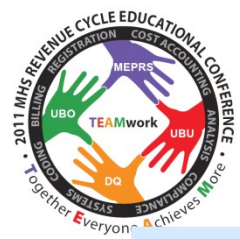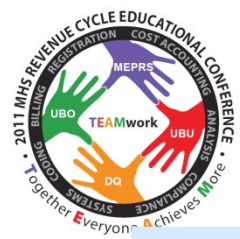- Key Players in Hospital Revenue Cycle

Registration/Admitting/Scheduling

- ❏ Scheduling
  - ➤ Inpatient/APVs
- ❏ Pre-Registration (Demographics)
  - ➤ Insurance Verification
  - ➤ Collection of signed DD From 2569
  - ➤ Medical Record/Account Number
- ❏ Pre-authorization/Certification
- ❏ Obtaining Consents
- ❏ Validate Physician's Orders
- ❏ Admit diagnosis
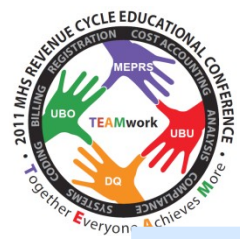- ❏ Collection of co-pays
  - ➤ Up-front collection

Clinical Documentation/Charge Capture

- Documentation of clinical services
  - Physicians
  - Allied Health Professionals
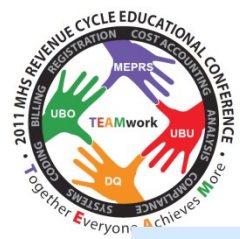 - Nurses

- Charge Capture
  - Timely and accurate charges

Note: Charge Master is not currently used in MHS

Case Management

❑ Pre-Certification

  ➢ Provide clinical information

❑ Length of Stay approval

  ➢ Provisional DRG

❑ Discharge Planning

❑ Medical Necessity Reviews

❑ Documentation Review

  ➢ Admit order

  ➢ Correct patient status

❑ Monitor if patients meet Inpatient criteria
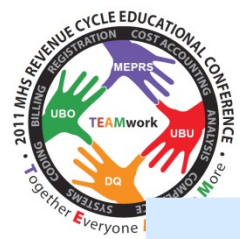
Medical Records

- ❑ Assembly and analysis
- ❑ Discharge/Encounter Reconciliation
  - ➢ CCE Reports/ADM/CHCS/AHLTA
- ❑ Coding/Abstracting
  - ➢ Inpatient & Outpatient Records
- ❑ Physician Documentation/Dictated Reports
  - ➢ **Example:** Discharge Summary, H&P
- ❑ DNFB (Discharges-Not-Final-Billed) Management
  - ➢ Unbilled Report
- ❑ Denial Management

Patient Financial Services

- Billing
  - Claim preparation after discharge
- Tracking outstanding accounts
  - Current Inpatients (LOS)
  - Accounts not coded post discharge
  - Final bills on hold due to errors
- Collecting/Payment Posting
- Customer Service
- Pre-authorization/Certification
  - Procedures
- Denial Management

Administration

- ❑ Develop strategic goals
- ❑ Operational policy

Finance

- ❑ Cash flow
- ❑ Contract management
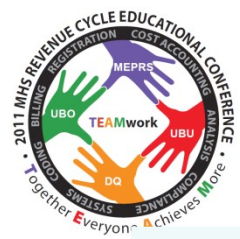
IT

- ❑ Systems (CHCS/AHLTA/CCE)

Ultimate Goal

Coordinated effort between Medical Records & Key Players

To Prevent loss of Reimbursement

Ensuring accurate billing, and
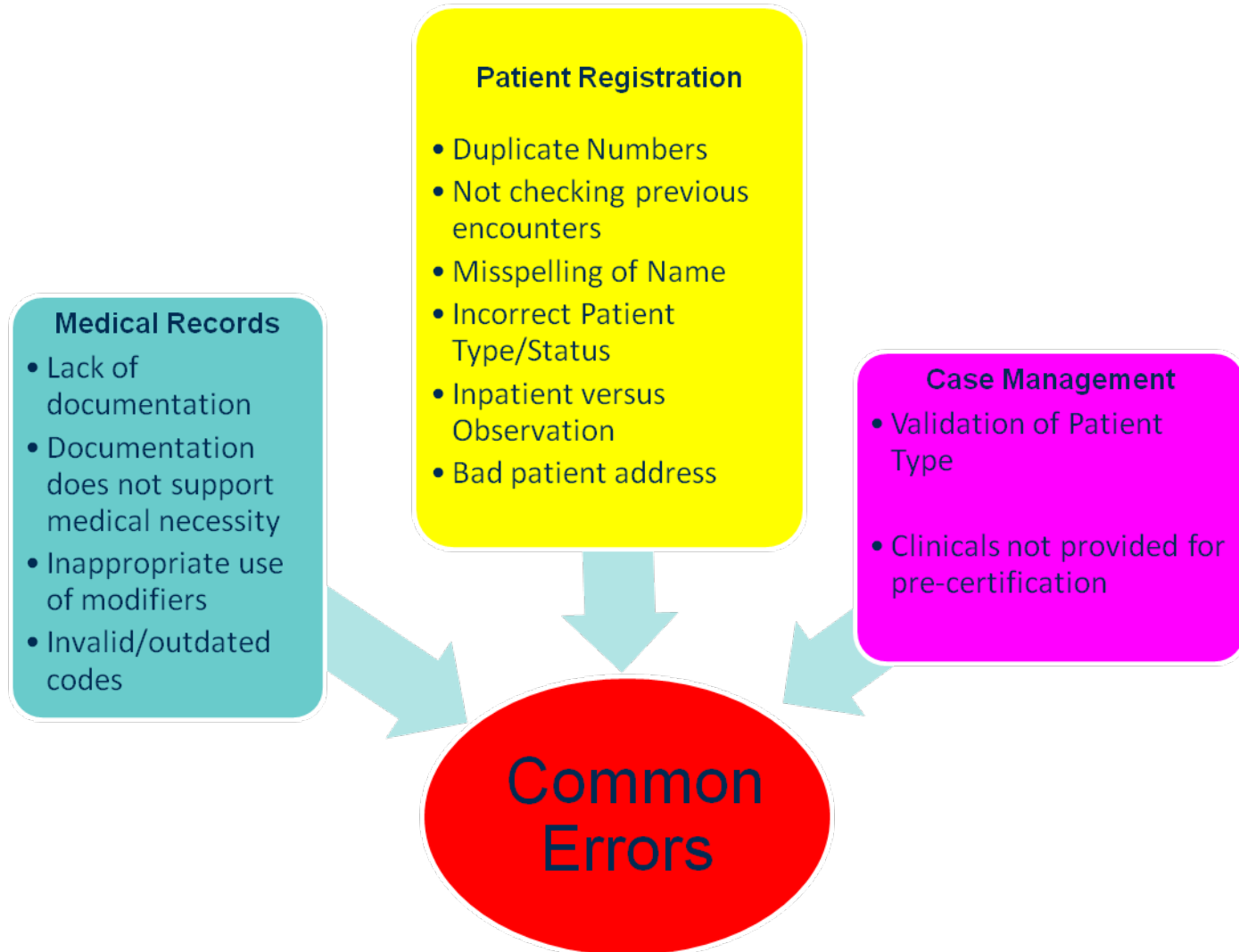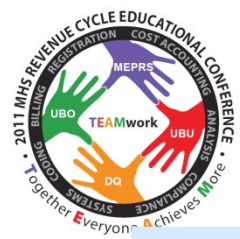
Accurate registration + correct coding = "clean bill"

Medical Records Role in Revenue Cycle

- ❑ If your MTF does not have a Revenue Cycle Team
  - ➢ Start one or become part of the team
  - ➢ Educate the key players
  - ➢ Become involved – be proactive!
- ❑ Medical Records has a wealth of contributions in functional expertise
  - ➢ Link between Registration & Billing
  - ➢ Coding compliance subject matter experts
  - ➢ Case Mix analysis specialist
  - ➢ DRG & APC expertise
  - ➢ Medical Necessity
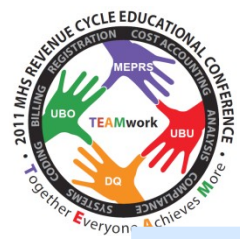 - ➢ Joint Commission/Medicare/Medicare regulation experts
  - ➢ Appeals & Denials experience

Revenue Cycle – Loss of Reimbursement

Medical Records

- Lack of documentation
- Documentation does not support medical necessity
- Inappropriate use of modifiers
- Invalid/outdated codes

Patient Registration

- Duplicate Numbers
- Not checking previous encounters
- Misspelling of Name
- Incorrect Patient Type/Status
- Inpatient versus Observation
- Bad patient address

Case Management

- Validation of Patient Type

- Clinicals not provided for pre-certification
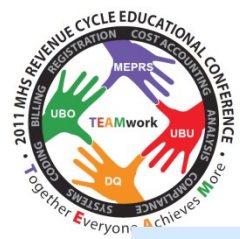
Common Errors

Medical Records Role in Revenue Cycle

❏ What can Medical Records do to assist in preventing these common errors?
  - ➢ Verify date of birth and/or SSN
  - ➢ Check name spelling
  - ➢ Dates of service
  - ➢ Validate correct patient type
  - ➢ Ensure medical necessity is met

❏ Trend recurrent errors and notify appropriate department

❏ Establish a good working relationship with all departments involved

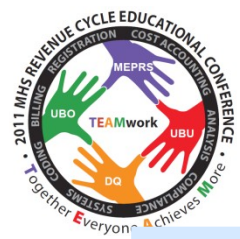❏ Communication is the key!

Medical Records Role in Revenue Cycle

- Medical Records holds one main key function in the reimbursement process:
  - Coding
- It is sometimes viewed as the only revenue cycle function
  - If records are not coded MTF will not be reimbursed
  - Workload will not be captured
- Other Medical Record functions are also important
  - Assembly and Analysis
  - Filing
  - Transcription
- Release of Information
  - Provision of records

Indicators that impact billing timeliness

☐ Record not received from unit

☐ Incomplete clinical documentation

☐ Ambiguous documentation necessitating physician queries

☐ Completion of assembly and analysis of the medical record

☐ Delayed or unavailable dictated reports/transcription turn-around time

☐ Coding Backlog

☐ Lack of coding staff

☐ System down-time

Medical Records Role in Revenue Cycle

- ❑ What can you do to manage these critical indicators?
- ❑ Perform tasks to ensure:

  - ➢ Accuracy of the coding and completion timeliness
  - ➢ Unbilled accounts are closely monitored by
    - ➢ Number of accounts/days post discharge
    - ➢ High dollar accounts
    - ➢ Reconcile admission & discharge reports
  - ➢ Documentation is properly documented in the patient's medical records
  - ➢ Processing of records post-discharge is on target
    - ➢ Accountability of all records
  - ➢ Benchmark Performance

Revenue Cycle Performance Measures

A/R Days

- Maintain between less than 30

DFNB
(Discharged, not final billed)

- < 2 days beyond bill hold

Bill-Hold Days

- Between 3-4 (some facilities have up to 6 or 7)
- Accounts should be monitored for charge posting
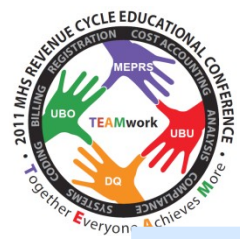
Coding Accuracy

- 95% rate
- At least one external audit
- Coding Education

Coding Productivity

- AHIMA Recommendation
  - Inpatient 24 charts per day
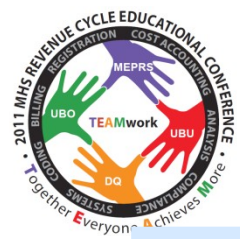 - ED 120 charts per day
  - APVs 40/day

Staff Turn-Over rate

- Stable staffing < 10 % turnovers
- Keep staff happy

❑ **Performance Improvement Opportunities**

➢ Assembly & Analysis

▪ Accountability & completion of medical record

➢ Evaluate loose paperwork

▪ Identify ways for improvement

➢ Transcriptionist turn-around time

▪ Track dictated report time

➢ Decrease coding backlog

▪ Enforce productivity standards

▪ Prioritize Records for coding

➢ Missing discharge records

▪ Continuous cycle for recovery of missing records
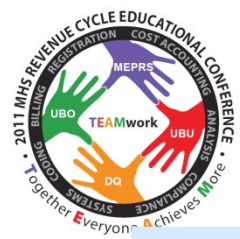
❑ **Performance Improvement Opportunities**

➢ Registration Errors
- Trend/Track common errors and notify department

➢ Delinquency Rate/Timeliness of Documentation
- Develop strategies for obtaining physician signatures and completion of documentation requirements

➢ Evaluate Staff Turn-over rate
  ➢ Staff Retention

➢ Educate and train entire staff in the role medical records plays in the Revenue Cycle

- Since **coding** is a key component of the Revenue Cycle focus on this function to streamline processes
  - Coding Productivity
  - Unbilled Accounts
  - Audit records monthly
    - Recurring edits
  - Perform focus audits
  - Trend physician queries
  - Discharge Dispositions
  - Coding Education
  - Physician Documentation – Utmost importance!!!
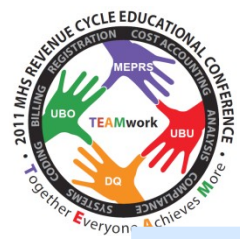   - Complete and legible
    - Continuous Process

- **Impact of Documentation & Coding**

  "If it was not documented – it was not done!"

- Prior to CMS implementation of the Prospective Payment System (PPS) impact was minimal
  - Coding function was ensuring diagnoses and procedures were on claim
- After PPS was implemented the focus was more on capturing complexity of patient population and increasing reimbursement
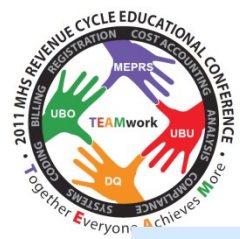 - Coding became a critical function
  - Documentation

❑ Impact of Documentation & Coding

➢ What is the importance of documentation?

- Documentation supports diagnoses and procedures coded on a claim/bill
- Documentation supports medical necessity for services rendered
- If documentation is ambiguous account cannot be final billed
  - Physician must be queried
  - Which leads to increase in Bill Hold Days

➢ What steps can you take

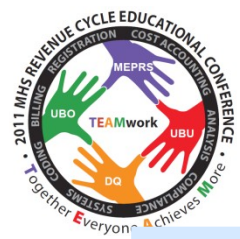- Conduct an assessment to determine your coding needs

❑ **Impact of Documentation & Coding**
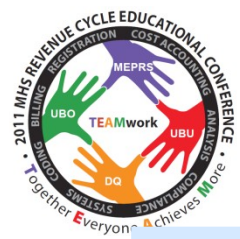
➢ Assessment Checklist Example

- Queries
  - ➢ Done for all patient types
  - ➢ Tracked and Trended
- Coding Quality
  - Are focus audits being conducted?
  - Are monthly audits for Inpatient and Outpatient Records?
  - Are internal & external audits done?
  - Is coder quality at 95%?
- Case Mix Index
  - Is it being trended?
  - Too high, too low?

- [ ] Implement a Clinical Documentation Improvement Program
  - ➤ Improves coded data
  - ➤ Leads to better documentation
  - ➤ Provide physician education
  - ➤ Decreases query backlog
  - ➤ Ensures compliance
  - ➤ Improve communication between physician and coders
- [ ] A CDI program means better documentation which leads to more accurate coding and less denials
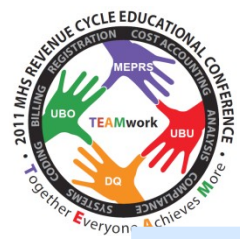
- Most denials can be prevented!
- Denied claims have direct impact on your MTFs bottom line – decrease in net revenue
  - Affects everyone
- Ultimate Goal
- Generate a "Clean Bill" and,
- Reimbursement is received
- ***"It takes a village"***
- Direct communication and cooperation between all key players is the answer!
- Continuous monitoring and process improvements = reduction of denied claims

❑ **Categories of Denials**

➢ Clinical

- Lack of pre-certification or length of stay authorization
- Lack of Medical Necessity

➢ Technical

- Wrong code assignment
- Improper modifiers
- Incorrect patient identification
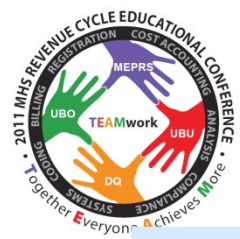- Duplicate claims
- Discharge disposition discrepancies

- **What can you do to prevent denials?**

  - Participate in your MTFs denial management program

  - If one is not in already in place
    - Suggest to your chain that a program be started

  - Establish a good working relationship with all key players
    - Patient Access/Scheduling
    - Admitting Office
    - Billing Office
    - Case Management
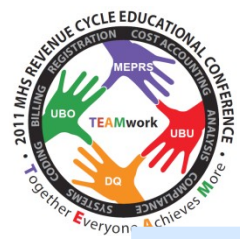   - Medical Director

  - Recommend weekly or bi-weekly meetings

Medical Records Role in Denial Management

- **What can you do to prevent denials?**

  - Become familiar with payer policies and requirements
  - Work closely with Case Management
    - Establish a process for case management review of records
      - That are missing admit orders
      - That have incorrect patient status
      - That have wrong discharge disposition
  - Participate in reviewing AHLTA templates to ensure codes are up-to-date
  - Conduct focus audits
    - Reconcile Coding Abstract Sheets with UB-92 or Form 1500

Medical Records Role in Denial Management

- **What can you do to prevent denials?**

- Work closely with the billing department
  - To identify types of denial claims
  - Reasons for denials
- Create a denial management database
  - Suggest using Access
- Track and trend denials that are related to coding or medical records completion, for example:
  - DRG or Coding errors
  - Not meeting medical necessity
  - Incomplete provision of medical record copies
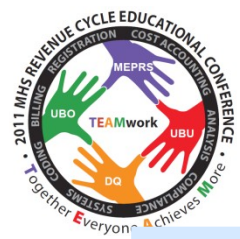
- **Appeal Tips**
  - Enlist the assistance of the Medical Director in writing/reviewing the appeal letters
  - Provide as much detail as possible to support your case
  - Ensure documentation reflects the coding
    - Add lab values, medications
  - Reference appropriate coding guidelines
  - Attach clinical documentation and other resources as necessary
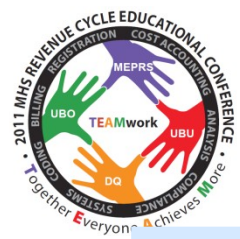
- ❑ **Additional Strategies**
  - ❑ Appoint a staff member dedicated to monitor Unbilled Accounts
  - ❑ Become very familiar with the Outpatient Prospective Payment System (OPPS)/OCE Edits
    - ❑ Invalid Diagnosis
    - ❑ Wrong sex
    - ❑ E-code as principal
    - ❑ Invalid Procedure
  - ❑ Continuous education process
  - ❑ Provide feedback to coders and providers
  - ❑ Evaluate processes and implement process improvements

❑ **Revenue Cycle**

  ❑ It's Everyone's Responsibility!

  ❑ Admitting/Scheduling

    ❑ Ensuring all patient's demographics and insurance information is accurate

  ❑ Clinical Documentation/Charge Capture

    ❑ Ensuring patient care is properly documented and charges are posted

  ❑ Case Management

    ❑ Ensuring admit orders are correct and admission criteria is met

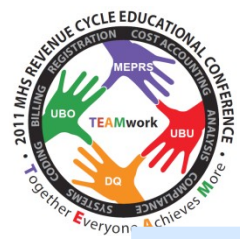 ❑ Billing Office

    ❑ Ensuring there are no duplicate claims
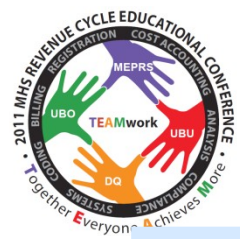
- **Medical Records Best Practices**
  - Documentation is clear and concise
  - Medical Necessity is being met
  - Capture of complication/co-morbidities
  - Case Mix is trended
  - Unbilled Report is continuously being worked on
  - Bill Hold days are within specified guidelines
  - Query process in place
  - Monitor Productivity
  - Audit and provide feedback
  - Provide coding education
  - Benchmark Performance

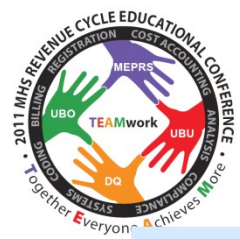# Role of Medical Records in the Revenue Cycle

- ❑ Since Coding is the key
  - ❑ Ensure coding timeliness
  - ❑ Coding compliance with official and MHS coding guidelines
  - ❑ Implement a CDI program to improve documentation
  - ❑ Create a physician newsletter to communicate coding changes
  - ❑ Develop a coding team newsletter to keep abreast of all new coding/policy changes
  - ❑ Focus audits and provide feedback and education
- ❑ Revenue Cycle is a continuous process
  - ❑ Front-end to back end-end
  - ❑ It's a never ending process!

Questions

- "Revenue Cycle Management Best Practices" Nadinia A. Davis, 2011
- APC Revenue Cycle: Tips for Success, Audio Seminar/Webinar, July 2009
- UBO Billing Manual, 2009
- "Getting the Most out of your Revenue Cycle", Audio Seminar/Webinar, January 2009
- Revenue Cycle, Health Care Management Association, September 2010
- "Effective Denials Management", Audio Seminar/Webinar, April 2009